# County Approver Certification

MH3273 (Rev 05/06)

## For Access to Confidential Mental Health Information

**County**: _____ (County Name and Number)

To ensure the confidentiality of county mental health data, the Department of Mental Health, Information Technology (DMH-IT) requests the county mental health director designate a primary and a secondary contact to be responsible for approving county staff requests for access to confidential patient data in the systems listed below. Please provide this information below and fax this form to (916) 654-3007. If you have questions about this form, please call (916) 654-3117.

### Primary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Primary Approver's Signature: _____

(Signer acknowledges having read DMH Letter No. 99-02 regarding Confidentiality of Client Information)

### Secondary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: (____) _____ Fax Number: : (____) _____

Email Address: _____

Secondary Approver's Signature: _____

(Signer acknowledges having read DMH Letter No. 99-02 regarding Confidentiality of Client Information)

### Appointed Vendor(s): (If applicable)

The vendor listed below has the authority to receive, send and process the above named county's confidential mental health information as marked below. The vendor will establish its own primary and secondary approving contacts.

Vendor Name: _____

Vendor Contact Name: _____ Phone Number: (____) _____

### Mental Health Systems:

**Please check the systems for which the above individuals and/or vendors may authorize access requests:**

- ☐ Client and Service Information System (CSI)
- ☐ Healthy Families Program (HFP)
- ☐ Monthly MEDS Extract File (MMEF)
- ☐ Provider / Legal Entity (PRV/LE)
- ☐ Statistics and Data Analysis (SDA)
- ☐ Mental Health Services Act (MHSA)
- ☐ Short-Doyle / Medi-Cal Claims – EOB (SDMC-EOB)
- ☐ Institutions for Mental Disease (IMD)
- ☐ Therapeutic Behavioral Services (TBS)
- ☐ Performance Outcome Data Systems (PODS)
- ☐ Cost and Financial Reporting System (CFRS)
- ☐ Admission, Discharge &Transfer System (ADT)

### County Mental Health Director Certification:

As Mental Health Director for _____ County, I designate the above individuals (and vendor if applicable) to have independent authority to approve access requests to specific confidential mental health patient data. DMH-IT may rely on approvals, denials, and changes made by the above individuals/vendor in its processing of access requests to this county's data in the systems listed above. As changes occur to the above approving contacts or vendor information (name, phone, e-mail), I will sign an updated certification and forward it to DMH-IT. Also, I acknowledge reading DMH Letter 99-02 regarding Confidentiality of Client Information.

_____ _____

County Mental Health Director (signed and printed) Date